STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

6/29/2016 PUBLIC NOTICE OF PROPOSED CATEGORY II CHANGE TO RHODE ISLAND'S COMPREHENSIVE 1115 WAIVER DEMONSTRATION

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) will seek federal authority to implement the following Category II Change to Rhode Island's Comprehensive 1115 Waiver Demonstration (project no. 11-W-00242/1):

Institutional Level of Care Determination Policy

As a result of the passage of the Reinventing Medicaid Act of 2015, EOHHS was granted federal authority to revise the clinical eligibility requirements for the "highest" level of care to access long-term services and supports. Since implementing this change, EOHHS has worked closely with providers, advocates, and patients to assess the impact of this change. As a result of that collaboration, EOHHS is now seeking federal authority to restore the original clinical eligibility requirements as described in the Rhode Island 1115 Demonstration Renewal dated 2/25/14.

This proposed Category II change is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by July 29, 2016 to Melody Lawrence, Executive Office of Health and Human Services, Hazard Building, 74 West Road, Cranston, RI, 02920, or melody.lawrence@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, a hearing will be conducted to receive public testimony on the proposed Category II change if requested by twenty-five (25) persons, or by an agency or association having at least twenty-five (25) members. A request for a hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or disability in acceptance for or provision of services or employment in its programs or activities.

Rhode Island Comprehensive Section 1115 Demonstration
Project Number: 11-W-00242/1

Category II Change
Change Name: Institutional Level of Care Determination Policy
Change Number: 16-02-CII

Date of Request	July 30, 2016
Proposed Implementation Date:	October 1, 2016

Fiscal Impact:

	FFY 2016	**FFY 2017**
State:	**$0.00**	**$0.00**
Federal:	**$0.00**	**$0.00**
Total:	**$0.00**	**$0.00**

Description of Change:
Attachment A

Assurances:
Attachment B

Standard funding questions:
Attachment C

Attachment A: Description of Change

Rhode Island is submitting a change request to the Rhode Island Comprehensive Section 1115 Demonstration, with an effective date of October 1, 2016 to make the clinical eligibility requirements for admission to a nursing home less stringent. This request is submitted as a Category II change.

Description:

In order to qualify for admission to a nursing home, an individual must be enrolled in the "Highest Needs" group. An individual who meets any of the following eligibility criteria will be eligible for the Highest Needs group:

1. An individual who requires extensive assistance* or total dependence* with at least once of the following Activities of Daily Living (ADL):

   Toilet Use Eating Bed Mobility Transferring

   AND the individual requires at least limited assistance* with any other ADL.

OR

2. An individual who lacks awareness of needs or has moderate impairment with decision-making skills AND one of the following symptoms/conditions, which occurs frequently and is not easily altered:

   - Wandering
   - Verbally Aggressive Behavior
   - Resisting Care
   - Physically Aggressive Behavior
   - Behavioral Symptoms requiring extensive supervision;

OR

3. An individual who has at least one of the following conditions or treatments that requires skilled nursing assessment, monitoring, and care on a daily basis:

   - Stage 3 or 4 Skin Ulcers
   - Ventilator/Respirator
   - IV Medications
   - Naso-gastric Tube Feeding
   - End Stage Disease
   - Parenteral Feedings
   - 2nd or 3rd Degree Burns
   - Suctioning
   - Gait evaluation and training;

OR

4. An individual who has an unstable medical, behavioral, or psychiatric condition(s), or who has a chronic or recurring condition that requires skilled nursing assessment, monitoring, and care on a daily basis related to, but not limited to, at least one of the following:

    - Dehydration
    - Internal Bleeding
    - Aphasia
    - Transfusions
    - Vomiting
    - Aspirations
    - Quadriplegia
    - Oxygen
    - Chemotherapy
    - Pneumonia
    - Septicemia
    - Dialysis
    - Cerebral Palsy
    - Multiple Sclerosis
    - Respiratory Therapy
    - Tracheotomy
    - Open Lesions
    - Gastric Tube Feeding
    - Radiation Therapy
    - Wound Care
    - Behavioral or Psychiatric conditions that prevent recovery;

OR

5. An individual who does not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Executive Office of Health and Human Services determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's health and safety.

* Definitions:

- Extensive Assistance (Talk, Touch, and Lift): Individual performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.
- Total Dependence (All Action by Caregiver): Individual does not participate in any part of the activity.
- Limited Assistance (Talk and Touch): Individual highly involved in the activity, but received physical guided assistance and no lifting of any part of the individual.

Attachment B: Assurances

The State assures the following:

- This change is consistent with the protections to health and welfare as appropriate to Title XIX of the Social Security Act (the Act)
- The change results in appropriate efficient and effective operation of the program, including Justification and Response to Funding Questions
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902,1903,1905,and 1906, current federal regulations, and CMS policy

Attachment C: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity, or any other intermediary organization? If providers are required to return any portion of payments , please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State(ie.,general fund, medical services account, etc.)

   Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment(normal per diem, supplemental, enhanced, other) is funded. Please describe whether state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures(CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not used by the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditures and State share amounts for each Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify the total expenditures being certified are eligible for Federal matching funds in accordance with 42CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   - (i) A complete list of the names of entities transferring or certifying funds;
   - (ii) the operational nature of the entity (state, county, city, other);
   - (iii) the total amounts transferred or certified by each entity;
   - (iv) clarify whether the certifying or transferring entity has general taxing authority : and ,
   - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations.)

The State share is funded through general revenue funds appropriated by the legislature for this purpose.

3. Section 1902(a)(30) requires that the payments for services be consistent with efficiency, economy, and quality of care . Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type .

   No supplemental or enhanced payments were made.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers(State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current(i.e., applicable to the current rate year)UPL demonstration.

   N/A

5. Does the governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced , other) exceed their reasonable cost of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   No governmental providers receive payments that in the aggregate exceed their reasonable costs of providing services.